FORM B10 (Official Form 10) (Rev. 4/98)

United States Bankruptcy Court
61288, Houston TX 77208

SOUTHERN DISTRICT OF TEXAS P.O.Box
(Houston Division)

PROOF OF CLAIM

Name of Debtors

____Stage Stores, Inc., a Delaware corporation
____Specialty Retailers, Inc., a Texas corporation
____Specialty Retailers, Inc. (NV), a Nevada corporation

*place an "x" beside the name of the Debtor you are filing a claim against

Case Number

00-35078-H2-11
00-35079-H2-11
00-35080-H2-11

Creditor ID#: 788-18162

United States Bankruptcy Court
Southern District of Texas
FILED

JUL 2 8 2000

Michael N. Milby, Clerk

Name of Creditor (The person or other entity to whom the debtor owes money or property):

Donna Marker

__ **Check box if you are aware that anyone else a filed a proof of claim relating to your claim. Attach copy of statement giving particulars.**

Name and address where notices should be sent:

**********AUTO**ALL FOR AADC 740
Donna Marker
PO Box 1588
Ponca City OK 74602-1588

__ **Check box if you have never received any notices from the bankruptcy court in this case**

__ **Check box if the address differs from the address on the envelope sent to you by the court.**

Account or other number by which creditor identifies debtor:

Check here if this claim __ replaces __ amends a previously filed claim, dated: _____

1. Basis for Claim

__ Goods sold
__ Services performed
__ Money loaned
_X Personal injury/wrongful death
__ Taxes
__ Other_____

__ Retiree benefits as defined in 11 U.S.C. § 1114(a)
__ Wages, salaries, and compensation (Fill out below)

Your SS#: _____ - _____ - _____

Unpaid compensation for services performed

from _____ (date) to _____ (date)

2. Date debt was incurred: On or about 06/03/99

3. If court judgment, date obtained: No Judgment

4. Total Amount of Claim at Time Case Filed: $ Undetermined

If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 below.

__ Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.

5. Secured Claim.

__ Check this box if your claim is secured by collateral (including a right of setoff).

Brief Description of Collateral:
__ Real Estate __ Motor Vehicle
__ Other All personal and intangible property of Debtor's Estate

Value of Collateral: $ ____

Amount of arrearage and other charges at time case filed included in secured claim, if any $ _____

6. Unsecured Priority Claim.

__ Check this box if you have an unsecured priority claim
Amount entitled to priority $ _____
Specify the priority of the claim:

__ Wages, salaries, or commissions (up to $4,300),* earned within 90 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(3)
__ Contributions to an employee benefit plan - 11 U.S.C. § 507(a)(4).
__ Up to $1,950* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(6).
__ Alimony, maintenance, or support owed to a spouse, former spouse, or child - 11 U.S.C. § 507(a)(7).
__ Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8).
__ Other – Specify applicable paragraph of 11 U.S.C. § 507(a-____).

Amounts are subject to adjustment on 4/1/98 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.

7. Credits: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim.

8. Supporting Documents: None *Attach copies of supporting documents*, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, explain. If the documents are voluminous, attach a summary.

9. Date-Stamped Copy: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

This Space Is for Court Use Only

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Date	Sign and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any):
7/24	Nicole Chambray Nicole Chambray

Penalty for presenting fraudulent claim: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

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FORM 3

SEND original + 2 copies to:
Workers' Compensation Court

WORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918

SPACE FOR COURT USE ONLY

FILED
039115 JUL -2 99
WORKERS COMPENS COURT COURT CLERK OKC

Name of Claimant (injured employee)
CHAMBRAY, Nicole
Name of Employer
Stage
Court Use Only

Please check (✓) the appropriate box

- [✓] I. This is an Original Filing of the Form 3
- [ ] II. This Amends a previous filing of theForm 3.

EMPLOYEE'S FIRST NOTICE OF ACCIDENTAL INJURY AND CLAIM FOR COMPENSATION

COURT CLAIM #

NOTE: A voluntary Mediation Program to address certain workers' compensation disputes is available through the Workers' Compensation Court. For information, call (405) 522-8760 or (800) 522-8210.

(Please type or print)

EMPLOYEE NAME (Last, First, Middle):	Social Security #:	Phone:
CHAMBRAY, Nicole	446-76-3577	(580) 402-0878

Mailing Address (include City, State & Zip):	Date of Birth: Age:	Sex:
815 1/2 N. Palm, Ponca City, OK 74601	1-7-80	F

Occupation	Was your employment agreement in	Avg. Weekly Wage:	Length of Employment:
Sales Associate	Oklahoma? YES [X] NO [ ]	218.50	years ____ months 9

Date of Accident or Last Exposure:	Injury resulted from:	Time Injury Occurred
On or About 6-3-99	Single Incident [X] Cumulative Injury [ ]	____ [ ] AM [ ] PM

Describe parts of the body injured or affected:	Place of Injury: City/County/State
Back	Ponca City/Kay/Oklahoma

What is the nature of the Injury or Illness:	Describe with details how the injury occurred. Include object or substance which directly injured you:
	Moving shoe shelves and felt pain in back

Treating Physician (full name):	Address:	City:	State:	Zip:
SJRMC, Ponca City				

Employer:	Employer's FEI # (Federal ID Number):	Telephone:
Stage		

Complete Mailing Address:	City:	State:	Zip:
14th Street, Ponca City, OK 74601			

Complete Street Address (if different from above):	City:	State:	Zip:

Are you a previously impaired person due to a prior workers' compensation injury or obvious and apparent pre-existing disability caused by accident, disease, birth defect or military injury? No If "YES", you may be entitled to Special Indemnity Fund benefits. Any claim made for Special Indemnity Fund benefits must be commenced by the filing of a "Form 3-F" with the Workers' Compensation Court and the Special Indemnity Fund.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly report in writing to the employer or insurance carrier any change in a material fact or the amount of income he is receiving or any change in his employment status, occurring during the period of receipt of such benefits.

I declare under penalty of perjury that I have examined this notice and claim, and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

ATTORNEY LIEN CLAIMED

Name of claimant's attorney if represented:

Type or Print Name of Attorney:	OBA#
Fred L. Boettcher	915
Mailing Address: P.O. Box 1588 Ponca City, OK 74602	
City 580-765-2541 State Zip	
Telephone #: ( )	

Signature of Attorney for Claimant

11/97

Upon filing this Notice of Accidental Injury And Claim For Compensation, permission is given to the Administrator of the Workers' Compensation Court, the Insurance Commissioner, the Attorney General, a district attorney or their designees to examine all records relating to the notice. The permission granted to the above named individuals or their designees authorizes them access to medical records pursuant to Section 19 of Title 76 of the Oklahoma Statutes, including waiver of any privilege granted by law concerning communications made to a physician or health care provider or knowlege obtained by such physician or health care provider by personal examination.

Signed this 1st day of July, 19 99

Signature of Claimant (shall be signed by claimant)

This form is not intended for use as a medical authorization.

Nothing shall be construed to waive, limit or impair any evidentiary privilege recognized by law.